

Patient's Name: _____

ALLERGIES (Use separate sheet if more space is needed)

Substance or Medication	Reaction (What Happens)

SURGERY (Operations)

What Operation?	Approximately When?

FAMILY HISTORY

	How Many?	List Health Problems
Mother		
Father		
Siblings		
Children		

TOBACCO

What type?	How Long?	When did you last use?

ALCOHOL

What do you drink?	How much?	How often?

EXERCISE

What type?	How long?	How often?

OCCUPATION

What do you do now?	How long have you done it?
What have you done longest?	How long did you do it?

IMMUNIZATIONS

Check any immunizations you had and the approximate dates if you know them.

Influenza	Hepatitis A	Meningococcus	
Pneumovax	MMR	Gardasil	
Tetanus	Polio	Zostavax	
Hepatitis B	Hemophilus	Other	